

# SHARING EXPERIENCES and EDUCATION on DIABETES



Using Bilingual Health Educators in Diabetes Prevention Education  
for Immigrant and Refugee Women  
Full Report of the Bilingual Health Educators Diabetes Project

# **Using Bilingual Health Educators in Diabetes Prevention Education for Immigrant and Refugee Women**

**Full report of the  
'Bilingual Health Educators Diabetes' Project**

**June 2010**

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The details of trainers, bilingual health educators and the organisations that arrange and/or hosted the diabetes prevention education sessions are listed in Appendix A.

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## ACRONYMS

ACCD	Australian Community Centre for Diabetes
BHE	Bilingual health educator
MCWH	Multicultural Centre for Women’s Health

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## PREFACE

This report offers insights into the delivery of diabetes prevention education for immigrant and refugee women using bilingual health educators. In this regard, the term 'bilingual health educator' is used in a particular professional context. The bilingual health educators referred to in this report have been trained and are employed by the Multicultural Centre for Women's Health (MCWH), a women's community health organisation based in Melbourne, Victoria, which has been providing health education programs to migrant and refugee women for over 30 years. Such a distinction is crucial in the context of addressing the specific and complex health needs of immigrant and refugee women. The organisation's bilingual health educators have undergone extensive, and continue to undergo, training in the delivery of health education to immigrant and refugee women in areas such as sexual and reproductive health, occupational health, mental health, drugs and alcohol, and financial literacy. The insights in this report on bilingual health educators' perspectives must therefore be considered in the context of MCWH's peer education model and participatory approach to health education.

This report describes and analyses data collected during two professional development initiatives for the MCWH bilingual health educators and describes the results of diabetes prevention education sessions conducted with women in the community.

It is highly recommended this report be read in conjunction with the pilot project report, *Diabetes Prevention for Immigrant and Refugee Women: Findings from the Diabetes Healthy Living Project* (2010) also published by The Multicultural Centre for Women's Health.

## EXECUTIVE SUMMARY

This report outlines the use of bilingual health educators in the delivery of culturally-appropriate diabetes prevention education and information. The information in this report has been collected as part of the 'Bilingual health educators—training and resourcing for working with immigrant and refugee women with or at risk of developing type 2 diabetes Project' otherwise known as *The BHE Diabetes Project*, conducted in partnership with the Australian Community Centre for Diabetes (ACCD) at Victoria University.

The aim of the project is to further develop the capacity of the MCWH bilingual health educators (BHEs) to deliver diabetes-related prevention and management programs to groups of women in metropolitan Melbourne. This report addresses the following objectives of the overall project:

- 1) To finalise a 2008 pilot study, *The Diabetes Healthy Living Project*, which involved training of bilingual health educators to deliver a diabetes education program to eight community-based immigrant and refugee women's groups across metropolitan Melbourne
- 2) Undertake two workshops with the BHEs who participated in the pilot study in order to develop:
  - a. Resources and education program methodologies for women, from the eight with or at risk of developing diabetes; and
  - b. Training modules for the BHEs to deliver these programs.

The report outlines the MCWH project achievements from the project's official commencement in June 2009 to May 2010. This report describes aspects of the project carried out by the MCWH, including specific recommendations to improve the training and the provision of resources to bilingual health educators.

This report contains:

- Findings of a MCWH bilingual health educators' resource development workshop conducted in November 2009;
- An evaluation of a diabetes prevention education training program conducted with MCWH bilingual health educators in March 2010; and
- An evaluation of thirty MCWH community diabetes education sessions conducted with 258 women during April and May 2010



# 1. BACKGROUND

The Multicultural Centre for Women's Health (MCWH) is a state-wide women's health organisation committed to improving the health of immigrant and refugee women across Australia. The MCWH has been providing health education and information to women in the workplace and community for thirty-two years.

The Centre's education program follows a holistic, peer education model, known as the 'woman-to-woman approach', which respects immigrant and refugee women's experiences and knowledge. Trained bilingual health educators (BHEs) conduct health promotion sessions for women in the preferred language of the participants, covering a range of women's health issues including sexual and reproductive health, occupational health, mental health, drugs and alcohol, and financial literacy.

The Centre provides health education to immigrant and refugee women in twenty languages and provides access to a comprehensive Multilingual Library and Resource Collection of over 90,000 items covering a range of languages. The Centre also specialises in intensive training programs for bilingual community workers.

## 1.1 The Diabetes Healthy Living Project

As part of ongoing efforts to reach women who would otherwise be unlikely to receive quality health education and information, MCWH implemented the *Diabetes Healthy Living Project* which aimed to increase the capacity of immigrant and refugee women to make healthy lifestyle choices (diet, exercise, health access) so as to minimise the likelihood of developing diabetes. The Project was made up of an education and a research component—each component was the responsibility of MCWH and D2West respectively.

The Diabetes Healthy Living Project was funded by the Ian Potter Foundation for twelve months and enabled the MCWH to successfully deliver 26 diabetes education sessions in eight languages to 104 women. The Diabetes Healthy Living Education Program was well-evaluated by the BHEs; however, BHEs suggested that the program could be improved with additional training and the provision of additional visual and multilingual resources (Poljski 2010).

## 1.2 'The BHE Diabetes Project'

In partnership with the Australian Community Centre for Diabetes (ACCD) and D2West (as lead agencies), the MCWH received additional funding via the Federal Department of Health and Ageing's Chronic Disease Self-Management Lifestyle and Risk Modification Grant to further develop the capacity of BHEs to deliver diabetes-related prevention and management programs to groups of women from eight language communities across metropolitan Melbourne.

The central focus of the current project is to build upon the success of *The Diabetes Healthy Living Project* (the 'pilot project') through, as the full project title suggests, the training and resourcing of the bilingual health educators:

Knowledge, skills and the perspectives of BHEs who were involved with a successful 2008 pilot study of working with immigrant and refugee women will be used to develop educational resources and methodologies, together with training modules for delivery of these in diabetes-related prevention and management sessions with women from the eight immigrant and refugee communities of the pilot study.

Brief Summary of Project, DoHA Funding Submission (2009)

At the completion of *The BHE Diabetes Project*, the MCWH delivered thirty sessions to 258 women from thirteen different language groups.

Table 1 outlines the project chronology.

**Table 1: Project Chronology**

<b>2008</b>	
Prior to 2008	Identification by MCWH of diabetes prevention gap in its health education program.
Feb	Funding application submitted to Ian Potter Foundation by MCWH (with research collaboration from D2West) to conduct <i>The Diabetes Healthy Living Project</i> .
March	Funding for <i>The Diabetes Healthy Living Project</i> granted by the Ian Potter Foundation.
September	The MCWH delivers a diabetes training program for all of the bilingual health educators.
December	MCWH delivers 26 diabetes education sessions to over 100 women from eight different language communities.
<b>2009</b>	
Feb	ACCD and D2West approach MCWH to collaborate on a diabetes prevention project.
March	ACCD submit ' <i>The BHE Diabetes Project</i> ', as lead agency and in partnership with MCWH.
May	Funding for ' <i>The BHE Diabetes Project</i> ' granted by DoHA
November	MCWH holds a workshop with bilingual health educators involved in the 2008 pilot study.
<b>2010</b>	
March	MCWH delivers a second diabetes prevention education training program based on the evaluation feedback received from the pilot study and the 2009 workshop.
April – May	MCWH deliver 30 education sessions as part of ' <i>The BHE Diabetes Project</i> '



## 2. INTRODUCTION

Health educators around the world continue to face the challenge of improving access to health services for people from immigrant and refugee backgrounds. It is well documented that immigrant and refugees from non-English speaking backgrounds are less likely to access mainstream health services, including access to adequate care and information (Von Hofe et al 2002). Reasons for such disadvantage include limited English skills/proficiency, socio-economic factors and lack of knowledge about available resources and services. In Australia, a quarter of the resident population are born overseas and an estimated 15% of these speak one of 190 languages other than English (ABS 2006). These statistics, coupled with the growing prevalence and incidence of chronic diseases such as diabetes within ethnic populations, highlight the challenges inherent in health care delivery systems. In response to the increasing diversity and chronic disease burden, governments at national and state levels continue to develop and support the delivery of health-promoting education (Milat et al 2009).

In this context, bilingual health educators (BHEs) have a significant role to play in ensuring the delivery of health information that meets the specific needs of migrants and refugees, especially those whose first language is not English and who prefer to communicate in their native language. Apart from increasing access to care and facilitating the appropriate use of health resources, the BHE can make an impact on quality of care provisions by contributing to the effectiveness of patient-provider communication. Effective and appropriate means of communication are thus integral to improving access as well as contributing to the delivery of high quality health services.

### 2.1 Who are bilingual health educators?

Although there is no single accepted definition of a 'bilingual health educator', the term can be broadly defined according to role and function. For example, there are different understandings of the ways in which *bilingual* workers are used and often distinctions are made between 'interpreting' and 'translating' (CEH 2004, 2008). It is also important to note that while culture is considered to be an important part of the definition of a bilingual worker, its terms and meanings are often contested (CEH 2008). This project refers to the BHE as a group *educator* and information provider who is trained to transfer and tailor the health information they learn in training into culturally-appropriate formats for their community.

In relation to the health sector more specifically, the BHE can be considered under the umbrella term 'community health worker'. Within this definition, the BHE is considered to be a lay outreach worker who acts as a cultural link between members of their community and health providers. Although the international profile of community health workers is highly diverse, there is broad agreement that community health workers 'should be members of the communities where they work' (WHO 2007: 1). There is also an assumption that bilingual health educators—in addition to the linguistic—share ethical, socioeconomic and experiential characteristics with the community in which they work (Andrews et al 2004). It is, however, inaccurate to assume that BHEs who come from and/or share similar characteristics with the community with whom they work automatically possess inbuilt or

'natural' knowledge about the best ways of delivering information to their community. As with the broader health services workforce, BHEs require on-going training in health-related topics including, for example, communication skills and evaluation. As pointed out in the WHO Policy Brief on successful community health programs: 'continuing or refresher training is as important as initial training...good continuing training [for community health workers] may be more important than who is selected initially (WHO 2007: 4).

## **2.2 Using bilingual health educators for diabetes prevention**

Although there is now ample evidence of the higher diabetes prevalence rates, including a higher risk profile, of certain individuals and groups from migrant and refugee backgrounds, there is yet little evidence as to the best models, methods and programs for diabetes prevention (AIHW 2008; Colagiuri et al 2007). Nevertheless, access to appropriate health services continues to be best addressed by the use of bi- or multilingual GPs and community health workers especially in relation to acceptability, feasibility and immediate impact (Colagiuri et al 2007). As pointed out in the research conducted for *The Diabetes Healthy Living Project*, the effectiveness of health promotion programs for immigrant and refugee women are often based on cultural inclusiveness, appropriateness and relevance, due to the lack of rigorous evaluations

The only clinically-tested example of a successful diabetes intervention using bilingual health educators/advocates has been documented in the United Kingdom (Greenhalgh 2009). A key finding of The POSEIDON (Promoting cOllaborative Support and Education in Diabetes for minOrity ethNic groups) Trial was that story-sharing groups for people from ethnic backgrounds with diabetes, which are facilitated by a bilingual health advocates, are better attended and produce significantly higher patient enablement scores than standard education. The study followed the development of a nationally (UK) accredited training program, 'story sharing for group learning', for bilingual health advocates (Greenhalgh and Collard 2003).

Given the research study's relevance to the BHE Diabetes Project and, in particular, to the MCWH model of health education, the lead investigator of the study, Professor Trisha Greenhalgh was invited to deliver a seminar at MCWH. Professor Greenhalgh's seminar, 'What can narrative-based medicine offer health educators?' was delivered to a large group of community workers and health professionals at the MCWH in July 2009.

## **2.3 The MCWH bilingual health educators**

There are twenty bilingual health educators employed by the Multicultural Centre for Women's Health who are trained to discuss sensitive women's issue in the preferred language of the participants. Their qualifications and experience are varied, ranging from overseas qualified health professionals to community workers and teachers. All BHEs have successfully completed a minimum 12-day training

course, on-the-job training and an assessment process, equipping them to facilitate small group health education sessions with women in their communities.

### 2.3.1 Recruitment

The bilingual health educators are recruited from the community every three years in order to keep pace with changing demographic and migration patterns and needs. A broad recruitment process is conducted, but specific educational facilities, such as English Language for Health Professionals courses for example, are targeted. A promotional program is conducted, information sessions, and expressions of interest are sought. As a result of this process, a group of between 6 to 10 women are selected to participate in the training program.

### 2.3.2 Training

The MCWH BHE training program is delivered face-to-face over a 3-4 week period for a total of 12 days. It is delivered by qualified trainers, which include in-house trainers (who hold Certificate IV in Workplace Training and Assessment), as well as externally-sourced trainers who provide specific expertise. The program is based on the principles of adult learning, accommodating a range of learning styles and including case studies, and opportunities for reflection and review.

The Centre's BHE Induction Training Program covers the following topics:

<b>Week One (Days 1-3)</b>	<b>Week Two (Days 4-6)</b>	<b>Week Three (Days 7-9)</b>	<b>Week Four (Days 10-12)</b>
<ul style="list-style-type: none"> <li>• MCWH Vision, Mission, Values</li> <li>• Organisational procedures</li> <li>• Quality standards</li> <li>• Health Education Programs</li> <li>• Evaluation</li> <li>• Communication and team work</li> <li>• Ethics and confidentiality</li> <li>• Women's Health - reproductive health</li> <li>• Cultural perceptions about women's health</li> <li>• Health education session demonstration – pap screening</li> </ul>	<ul style="list-style-type: none"> <li>• Women's Health continued – reproductive health</li> <li>• Health education session demonstration – contraception</li> <li>• Sexual health</li> <li>• Working with interpreters</li> <li>• Mental health and wellbeing</li> </ul>	<ul style="list-style-type: none"> <li>• Alcohol and other drugs</li> <li>• Alternative medicine/therapies</li> <li>• Planning and evaluation of education sessions</li> <li>• Facilitation skills</li> <li>• Using visual materials</li> <li>• Occupational health and safety</li> </ul>	<ul style="list-style-type: none"> <li>• Multiculturalism, Gender and Human Rights</li> <li>• Work-place discrimination, sexual harassment</li> <li>• Session planning and evaluation</li> <li>• Assessment</li> </ul>

After the 12-day training program, trainees participate in on-the-job training, attending health education sessions as an observer, and then conducting their own session under observation. Following this process, a final assessment is conducted and if successful, trainees become working members of the BHE team.

Specific training for different topics, such as diabetes prevention, is conducted regularly with the BHEs in order to update or add to BHEs' skills and knowledge. In the past year, the BHEs have undergone training in financial literacy, sexuality, and domestic violence.

### **2.3.3 Education Delivery**

The Centre's BHEs deliver education sessions against a set of quality standards which guide the development, implementation and evaluation of the sessions. The quality standards are: Women's Empowerment; Cultural and Linguistic Appropriateness; Accuracy of Health Information; Access and Equity; Confidentiality; Collaboration; and Continuous Improvement

The bilingual health educators approach the women in the sessions as peers and not as experts who will tell them what is best for them. Women are given a choice as to how much information they would like; how much they would like to be involved in discussion; and are acknowledged for their own experience and knowledge. Confidentiality is assured from the beginning.

The implementation of a storytelling or 'narrative' technique, as it is most commonly known in public health research (Hinyard and Krueter 2006), has a direct relevance to the MCWH approach to health promotion. While 'sharing stories' has always featured in MCWH health education sessions since the Centre's inception over thirty years ago, a narrative approach was first formally incorporated and utilised in the delivery of a credit education program in 2008 (Poljski and Murdolo 2009). The case study discussions, as they were referred to in the credit program, was used an evaluation tool by the BHEs. The case studies also proved to be effective in facilitating a better understanding of the possible problems and solutions to women's problems and issues than 'standard education'. The case study/narrative approach was subsequently and successfully used in the pilot Diabetes Healthy Living Project. This gendered approach to diabetes prevention using story-telling as the main education strategy was the first of its kind in the world (Poljski 2010).

The education sessions are supported by written resources which are prepared in the language of the group and distributed to individual women. Resources are designed to offer women additional resources in their preferred language (including English) and for future reference.

### **3. PROJECT FINDINGS**

The BHE Diabetes Project was funded to deliver two workshops with all twenty of the MCWH bilingual health educators. A key finding of the Diabetes Healthy Living Pilot Project was the lack of culturally-appropriate visual resources for use in the education delivery. As such, the workshops were designed to provide a structured forum for BHEs to collectively plan and develop diabetes prevention education resources tailored to women from different communities. It was decided, however, that only one resource development workshop would be necessary to meet the ACCD's objective of developing culturally-appropriate resources. A workshop was conducted with the eight BHEs who had experience of delivering the sessions in the pilot project. In addition, because it had been more than twelve months since all the BHEs had received diabetes prevention training, a two-day training program was run to ensure that all BHEs would have the opportunity to refresh and update their knowledge.

#### **3.1 The Bilingual Health Educators' Resource Development Workshop**

The following BHEs attended the workshop on 11<sup>th</sup> November (according to language spoken):

- Amharic
- Arabic
- Italian
- Macedonian
- Sudanese Arabic
- Turkish
- Vietnamese

(The Tagalog-speaking/Filipino BHE was unable to attend.)

ACCD project staff also attended the one day workshop in order to seek the BHEs' input for resource development.

##### **3.1.1 The MCWH approach to diabetes prevention education**

The workshop began with an overview of the MCWH's approach to education specifically in relation to the principles underpinning the participatory peer education model. Bilingual health educators were asked what they considered to be the 'woman-to-woman' approach and what the approach meant to them (see Box 1).

The BHEs' responses were then discussed in the context of developing practical resources, which align with the principles and values of the model.

BHEs generally perceive their work as influencing women's ability to self-direct their learning, by providing options that are practical and relevant to the women's everyday lives.

*'I always try to relate the information I have to deliver to my life – how would I use it? – before I even think about how I can relate the information to the group.'* (BHE 1)

Examples of diabetes prevention messages, which were considered to be effective in directing women to healthier lifestyles include:

- practical information around exercise;
- healthy food is not boring: a message that should be conveyed through modification (as opposed to abstinence);
- practical demonstration (making water and healthy snacks available at the sessions); and
- cooking tips (although some women might know how to choose healthy foods, they don't often know how to prepare the food for their families and what size portions are optimal).

## **Box 1: The Woman-to-Woman Approach—what it means for bilingual health educators**

### **Gender-based**

'It's a one-on-one approach that takes into account a woman's perspective on issues and problems.'  
(There was mention made of men, who were aware of an education session being conducted, requesting information to take home to their wives)

'It is about tapping into women and allowing them to talk—we only facilitate: it is the women who have the experience...their stories provide all the important information to other women in the group.'

'Women are usually more open and have more of a capacity to talk about themselves with others.'

### **Respect**

'It is not about being a friend or an authority, but about presenting oneself as a professional who can garner respect.'

### **Trust**

'We're establishing trust.'

'In some cultures, there is stigma attached to talking about certain types of illness, but if and when women begin to feel comfortable they will usually open up. The approach can help with this process.'

### **Mutual Exchange**

'[Peer education] is about the fluidity of exchanging roles at the level at which the women are sharing and keeping the dynamic intact'.

'It is an approach that is as much about giving as taking through a sharing and learning process.'

'Sharing stories not only encourages openness, but ongoing exchange of ideas after the sessions.'

'Some older women groups traditionally don't accept being given advice by a younger woman, but they readily welcome me [as a younger woman] providing them with information, perhaps this is a sign of adapting to Australian values.'

### **Cultural Appropriateness**

The matching of culture and language are seen as important aspects:

'When I was waiting to deliver a session, some of the women asked me in our language, "When is the white woman arriving [to conduct the session]?" I told them, "I am your white woman". The women were so surprised and excited to hear that.'

### 3.1.2 The Case Studies

*'The storytelling makes [health education] real and possible'. (BHE 2)*

The BHEs were clear about continuing the use of case studies in the education session mainly due to their effectiveness as a teaching strategy in the pilot project (the overall rating for the use of case studies was a **9** on a scale of 1 to 10, with 10 being 'excellent'). While the use of case studies has been and can be used as a tool to evaluate women's knowledge needs and to facilitate discussion, the relevancy of women's stories as a form of hope and encouragement for other women in similar situations was cited as a major reason for continuing the use of case studies.

Although all BHEs felt they could confidently recount their own case studies for use in the sessions, the provision of a range of case studies as resource options is considered to be beneficial, so that different approaches for each group can be used. A BHE recounted a story told by one of the women in an education session (see Box 2), a story which the BHE has retold to other groups as a case study in order to highlight friction and conflict issues when a family member has diabetes. Bilingual health educators recommended that case studies should be presented in a way that incorporates the family context/environment as a whole.

#### **Box 2: A case study based on a woman's own story**

Delia had been having problems in her marriage. In addition to other problems, her husband often blamed her for his impotence even though he was also suffering from other health problems and was drinking heavily. After Delia pleaded with him to seek medical advice, he finally visited a doctor and was told he had type 2 diabetes. The doctor also explained type 2 diabetes was more than likely the cause of many of the health problems he had been experiencing. Delia's husband apologised to Delia for his past behaviour and began to take steps to improve his health. The couple's relationship has since improved.

### 3.1.3 Education Resources

In general, the BHEs requested visual material that is at least A3 size but preferably in a large poster-size format. Posters/charts should be image-based with minimal information and/or text in order to cater for lower literacy levels and variations in dialect.

The following table outlines the specific suggestions for resource development.

**Table 2: Resource Development Suggestions**

Resource	Comments
A body chart and/or simple anatomical model	<ul style="list-style-type: none"> <li>• Mention was made of women's lack of knowledge of anatomy.</li> <li>• Posters/charts with more 'clinical' information are not very suitable for presentations and are better used by BHEs to refresh and enhance their own knowledge and understanding, rather than for presentation in the community.</li> </ul>
Visuals depicting the progressive signs of diabetes with a comparison of a healthy body	
Visual aids for the case studies	<ul style="list-style-type: none"> <li>• Including a story board and 'family' photographs</li> </ul>
Food portion-size aids	<ul style="list-style-type: none"> <li>• Using the hand to measure portions</li> <li>• A food portion plate</li> <li>• The 'traffic lights guide', which represented food as either 'red' (eat least), 'yellow' (eat in moderation) or 'green' (eat most) was identified as good examples of visuals</li> <li>• Laminated visuals of food portions</li> <li>• Any visuals of food should depict daily allowances</li> </ul>
Food pyramid aids	<ul style="list-style-type: none"> <li>• Should not have too many pictures and information as it can become confusing for some women (especially where literacy levels are relatively low) in terms of understanding portion sizes e.g. they are informed that one banana represents a portion yet the picture shows them three bananas.</li> <li>• An empty pyramid with Velcro/stick-on on which they can 'create' meals with appropriate portions during presentations.</li> <li>• smaller fridge magnet of food pyramid</li> </ul>
Visual depicting the perceived 'benefits' of take-away food	<ul style="list-style-type: none"> <li>• Images should include fat and sugar content</li> </ul>
'True or False' quiz	<ul style="list-style-type: none"> <li>• a quiz outlining the key points</li> </ul>

### 3.1.4 The Education Modules

The education modules used in the pilot project consisted of four modules:

- Module 1: What is diabetes?*
- Module 2: Why am I at risk of developing Type 2 diabetes?*
- Module 3: How can I prevent Type 2 diabetes?*
- Module 4: Where can I go for more information and support?*

The modules were designed to be covered consecutively in two 2-hour sessions. Bilingual health educators were informed that the modules would be updated and a fifth module covering gestational diabetes will be developed to form part of the diabetes prevention education program. Although all BHEs are happy with the content of the modules, they also suggested delivery of the modules could be improved with the inclusion of more nutrition information, including additional training in the area. Other suggestions included: highlighting mental health issues; working with a community leader in the session to talk about their experience with diabetes; and including a market visit.

All BHEs were made aware that the revised and updated modules which make up the diabetes prevention education program can be tailored depending on the time allocated for each session.

The main concern expressed by the BHEs is whether there might be enough time to use the case studies as a knowledge assessment tool (in the pilot program, BHEs had the opportunity to conduct three 2-hour sessions—a total of 6 hours). The BHEs were advised to continue to use the case studies, at their discretion, as a tool for one or more of the following:

- to introduce general facts about diabetes and prevention;
- to facilitate discussion;
- to clarify/review information; and
- to reinforce key messages.

## 3.2 BHE resource development workshop: evaluation

A comprehensive workshop evaluation was conducted with the BHEs by MCWH project staff at the end of the workshop (see Appendix B) specifically in relation to content and desired results. On a scale ranging from 1 to 5 with 1 being 'strongly disagree' to 5 being 'strongly agree', all BHEs either agreed or strongly agreed with the statements provided about the workshop. In particular, most of the BHEs **strongly agreed** that the content and the issues covered were relevant to their work as a bilingual health educator. The BHEs also **strongly agreed** that they were able to contribute to the discussion and that they could use what they learnt.

In relation to aspects of the workshop which are most valuable and relevant to their work, BHEs commented that it was the opportunity to exchange ideas with colleagues. As one BHE wrote, it was

valuable for them 'to hear the opinions from the other BHEs...and write down some new approaches and options in order to deliver better service to the community'. (BHE 3).

Table 3 presents the impact evaluation findings of the workshop.

**Table 3: Evaluation of the BHE Resource Development Workshop**

The Workshop has...	<i>On a scale ranging from '1- Not at all' to '10- Completely'</i>
...increased my understanding of evaluative thinking	9.3
...increased my knowledge about participatory peer education	9
...given me an understanding of good practice in health education delivery	9
...helped me to identify my learning needs as a BHE	9
...increased my understanding of storytelling techniques	9.1
...reinforced my understanding of adult learning theory and principles	8.7

### **3.3 Diabetes prevention education bilingual health educator training program**

All of the MCWH bilingual health educators were trained in diabetes prevention education in September 2008; however, only eight of the BHEs were funded to deliver sessions for the pilot project. The feedback received from the BHEs in the pilot project was the need for longer and/or additional diabetes training. Although the BHE Diabetes Project was funded to deliver a second resource development workshop with BHEs, the MCWH project team identified the need for *all* BHEs to improve their ability to deliver diabetes education sessions in the community. A two-day training program for all BHEs was subsequently conducted in March 2010 to meet BHEs' professional development needs and to ensure their knowledge of diabetes prevention is up-to-date.

While the gendered narrative approach continued to be a theme in the second training program (it was a core component in the 2008 training program), there was more emphasis placed on healthy eating for the prevention of diabetes. A separate session on gestational diabetes was also included in the program for the first time (see Appendix D).

#### **3.3.1 Evaluation of the bilingual health educator diabetes prevention training program**

A comprehensive evaluation survey about the training program was administered to the BHEs at the completion of the two-day program. On a scale from 1 to 10, with 1 being 'poor' and 10 being 'excellent', the quality of the training program was given an overall rating of **9.7**. The BHEs also rated

highly the informative nature of the training (**9.3** on a scale from 1 to 10, with 1 being 'not at all' to 10 being 'extremely') and indicated that the program met their needs as a bilingual health educator (**9.2** on a scale from 1 to 10, with 1 being 'not at all' to 10 being 'completely').

The evaluation results are consistent with, and in some aspects exceed, the favourable results of the training program delivered during the pilot project. All feedback received from the BHEs in relation to future improvements to the diabetes program were incorporated in the latest training program. The effectiveness of the training program in meeting the BHEs' practical professional needs can also be attributed to the ways in which the information was presented to the group, as is pointed out by two BHEs:

*'The training program explains 'why'. For example, why does exercise help people... 'open more gates'...? And [the] training program provided us with fun activities (e.g. quiz, drawing on white board to explain, label reading, visual aid and discussion, teaspoon sugar bags for people to visualise how much sugar consumed.'* (BHE 4)

*'Messages were presented in lay-people... terms and explanations so we can use it in the community and [the presenters] used techniques and guides to do similar things in the community session as well.'* (BHE 5)

The comments substantiate the benefits of using presenters with knowledge of and experience in women's health and the community health sector. Project staff ensured that all the presenters were sourced from within the community health network and briefed all presenters about the professional needs and knowledge requirements of the group. Both the diabetes educator (Roger Lindenmayer, from North Richmond Community Health Centre) and the dietitian (Julie Lew, from Merri Community Health Centre) who presented at the training were involved in the pilot project and had good working knowledge of MCWH programs and activities: each presenter was rated **9.5** and **9.2** respectively for their presentations; with the BHEs rating each presentation's ability to increase their knowledge and understanding of diabetes-related issues a **9** and **8.5** respectively.

The gestational diabetes training session presented by diabetes educators (Deborah Boyd and Catherine McNamara) from the Mercy Hospital from Women was rated a **7.9** for both the presentation and for increasing BHEs' knowledge and understanding about gestational diabetes. The relatively lower rating given to this particular session is neither an indication of quality of the presentations nor about knowledge priority or need for BHEs, but about the lack of time allocated to the topic. More than half of the BHEs commented there was not enough information provided during the one session allocated to this topic. During the 45 minute session, there was spirited discussion and many questions were asked by the BHEs in response to the information provided. As one BHE pointed out, 'The guest speakers were all clear in delivering the information, and they took the time needed for us to clearly understand the information.' (BHE 6)

It should also be noted that for both the healthy eating and diabetes-specific sessions, which were allocated a total of six sessions (total of 9 hours) over the two-day program, the majority of BHEs indicated that sufficient information was provided, as one BHE put it, 'I think the training went really

well considering the amount of information we were presented and the time available.’ (BHE 7) Nevertheless, the issue of more time being allocated for training programs, particularly in the context of limited resources, continues to be a challenge for the organisation.

The majority (90%) of BHEs who responded to the question about additional diabetes and training and education needs requested regular, on-going training to update their knowledge and additional (visual) resources for use in the education sessions.

**Table 4: The BHE training program: overall ratings for training sessions**

Session/Topic	Overall rating (out of 10)
<p><b>‘Healthy Eating for Diabetes Prevention’</b></p> <ul style="list-style-type: none"> <li>• Presentation by Julie Lew, Dietitian, Merri Community Health Service</li> <li>• Extent to which presentation increased knowledge and understanding of diet and nutrition in relation to diabetes</li> </ul>	<p style="text-align: center;"><b>9.2</b></p> <p style="text-align: center;"><b>8.5</b></p>
<p><b>‘What is diabetes: what happens and why? Managing and coping.’</b></p> <ul style="list-style-type: none"> <li>• Presentation by Roger Lindenmayer, Diabetes Educator, North Richmond Community Health Centre</li> <li>• Extent to which presentation increased knowledge and understanding of diabetes</li> </ul>	<p style="text-align: center;"><b>9.5</b></p> <p style="text-align: center;"><b>9</b></p>
<p><b>‘Gestational Diabetes: What women need to know’</b></p> <ul style="list-style-type: none"> <li>• Presentation by Catharine McNamara and Deborah Boyce, Diabetes Educators, Diabetes in Pregnancy Unit, Mercy Hospital for Women</li> <li>• Extent to which presentation increased knowledge and understanding of gestational diabetes</li> </ul>	<p style="text-align: center;"><b>7.9</b></p> <p style="text-align: center;"><b>7.9</b></p>

### **3.4 Diabetes prevention education sessions for immigrant and refugee women**

#### **3.4.1 Resources**

The Multicultural Centre for Women’s Health was not funded to develop resources for the education sessions; however, a variety of low-cost resource options were produced to meet the needs of the BHEs.

##### *BHE Resource Kit*

During the pilot project, each BHE was given a comprehensive resource kit of diabetes-related resources containing over forty handouts and other resources sourced from a number of Australian

websites and organisations including the Better Health Channel; Diabetes Australia/Vic/NSW; Jean Hailes Foundation for Women's Health; and the National Health and Medical Research Council. Additional resources were added to this kit during the project. Additions to the kit continue on an on-going basis.

### *BHE Education Manual*

At the completion of the training program, all BHEs received an updated diabetes prevention education manual. The manual builds on the Diabetes Healthy Living Project: Education Program Kit. It contains five modules for diabetes prevention education, which can be delivered in two 2-hour sessions. The five modules are:

- Module 1: What is diabetes?*
- Module 2: Gestational Diabetes*
- Module 3: Why am I at risk of developing Type 2 diabetes?*
- Module 4: How can I prevent Type 2 diabetes?*
- Module 5: Where can I go for more information and support?*

Each module states the aims and learning objectives to be achieved by the end of the module, as well as important points to be addressed during discussion. A separate 'discussion notes' section and delivery tips are also provided with each module for reference and to remind BHEs of the key messages to be shared with participants during the sessions.

The BHEs were advised that the modules should only be used as a guide for facilitating diabetes prevention education sessions and are to be used in conjunction with other resources available through MCWH's Multilingual Library and Resource Collections (multilingual fact sheets, leaflets, posters, food models, etc).

The latest diabetes prevention education training notes and handouts provided by the external trainers were included in the manual. As with the BHE Resource Kit, the manual is continually updated.

### *Anatomical Charts*

A laminated A3 size diagram of a simplified anatomical chart was also provided to BHEs following their requests during the training program. The 'Diabetes Roger' Chart—as it was unofficially named by the BHEs—was used by Roger Lindenmayer, the diabetes educator, to visually demonstrate the role of insulin in relation to the passage of glucose in the bloodstream. The reusable chart can be used with a whiteboard marker and allows BHEs to explain, draw and write (in more or less detail) the role of insulin in the women's language.

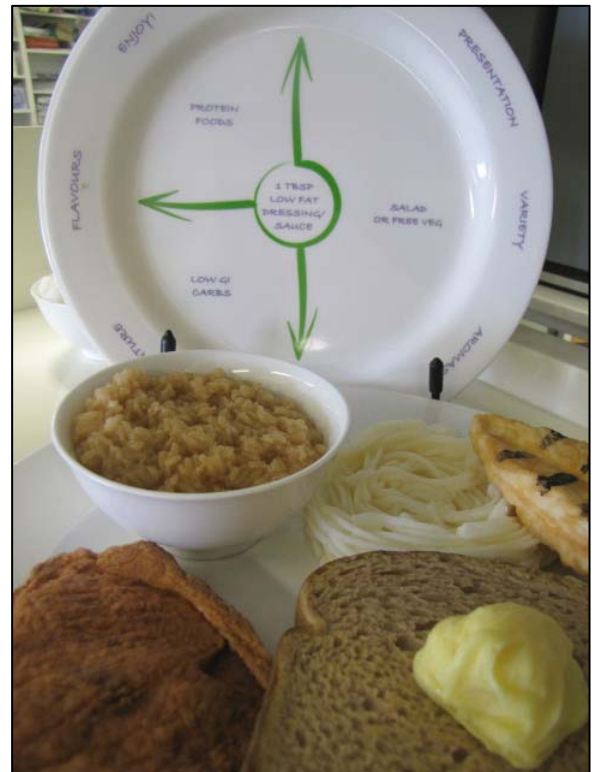
### *Life-size photo food guide*

A life-size photo food guide for daily food requirements and portions was used and highly recommended by the dietitian during the training program. The food guide, produced by an

accredited practising dietitian and accredited nutritionist, allows women to immediately see portion sizes without the need for complex measures or maths. The BHEs were instructed to use this resource book to allow women to compare foods quickly by looking at the photos and to show food serving sizes and food choices that are the best for good health.

#### *Food portion plate*

A dedicated food portion plate was purchased to visually demonstrate the recommended meal portions. The BHEs were advised to use the plate provided as a guide and encouraged to use other teaching strategies/activities with the women, such as drawing on paper plates or actual plates with a whiteboard marker, to demonstrate food portions. Bowls in various sizes are also provided for individuals who do not typically eat from a plate.



#### *Food Packages*

Following the advice of the dietitian trainer, a box file of empty food package containers and cartons was also put together. The food package box file covers all the major grocery/food items including dairy, pasta, rice and cereal products. The BHEs were advised to use this resource for label reading and demonstration with women in the education sessions. Efforts are now underway to add food packages available from ethno-specific specialty stores to complement the food stocked by the major grocery outlets.

#### *Food Replicas*

Different types of replica food models were purchased as a complement to the food resources mentioned above. Food replicas include a dietary recommended portion of meat, chicken, pasta, brown and white rice and fat (butter). The BHEs were advised to use the models in conjunction with the other food resources for visual effect and interest.

#### *Food Demonstration*

The provision of healthy food at the diabetes prevention sessions conducted during the pilot project proved to be a successful teaching and learning resource. Forty dollars was allocated for BHEs to spend on an optional food activity and/or healthy food demonstration for each group participating in the current project. If they chose to use a food demonstration during a session, BHEs were instructed to use the money at their discretion depending on the learning needs of the women in the sessions. Options include buying healthy food to be eaten by, or given away to, the women during the session or preparing and/or cooking food.

While resource development and production continue to be an issue in terms of time and cost, the resourcefulness and expertise of the Centre's BHEs cannot be underestimated. Each of the BHE's exemplary facilitation skills, coupled with the ability to improvise and to customise information to the needs of the women, play an integral part in the effectiveness of the resources.

**The education sessions:**



**Image 1: Visualising the message**



(Image courtesy of Marianna Jerbic)

**Image 2: Healthy refreshments**



Image 3: Healthy food as education resource



Image 4: Label reading

### **3.4.2 The education sessions**

The BHE Diabetes Project was funded to deliver 24 education sessions covering eight languages. The initial rationale for delivery of the sessions was to replicate the 3-session delivery model used in the pilot project; however, a change in project direction meant that education sessions were subsequently booked according to demand in the community.

Unlike the pilot project, no academic research was conducted on the sessions. As such, additional diabetes-related information about the women was not collected.

The logistics of education delivery, including the tight project timeframe, depended on requests by the community groups. The majority of education sessions were booked for community groups at their usual location and time of meeting. As such, all the sessions were delivered in either one or two hour blocks with a maximum of two sessions per group.

Overall, thirty diabetes prevention education sessions were conducted. A total of 258 women from thirteen different language groups participated in the session. Due to the unavailability of health educators in particular languages, the sessions delivered to women speaking Assyrian, Karen, Polish, and Punjabi were conducted in English with assistance from an interpreter. (The BHEs who delivered the education sessions are listed in Appendix A).

The largest language group—nearly a quarter—who participated in the education sessions were Cantonese-speaking women (23%), followed by Macedonian-speaking women (20.9%). As an example of the particular and varied session-delivery challenges required of the BHE, the Cantonese session was delivered in a one-hour session whereas the Macedonian sessions were delivered to four different groups, with each group receiving two one-hour sessions. In order to meet the education needs of the groups, each BHE planned and prepared appropriate teaching and learning strategies and resources to take into account factors such as group size and the likely level of interaction within each group.

Of the 258 women, nearly half (46.5%) were 61 years and over. This statistic reflects the requests made by migrant resource centres for diabetes prevention education sessions to be conducted with positive ageing and senior citizens groups.

Table 5 summarises the demographic background of the women who participated in the education sessions

**Table 5: Demographic information of women who participated in the education sessions**

<b>Demographic</b>	<b>Number of women</b>	<b>% of women</b>
<b>Main Language Spoken</b>		
Arabic	20	7.8
Assyrian	15	5.8
Cantonese	60	23.3
Croatian	10	3.9
Dari	10	3.9
Italian	14	5.4
Karen	15	5.8
Macedonian	54	20.9
Polish	15	5.8
Punjabi	12	4.6
Somali	9	3.5
Sudanese	12	4.6
Vietnamese	12	4.6
<b>Total</b>	<b>258</b>	<b>100</b>
<b>Age</b>		
18-30 years	28	10.9
31-40 years	16	6.2
41-50 years	26	10
51-60 years	68	26.4
61+ years	120	46.5
<b>Total</b>	<b>258</b>	<b>100</b>

### **3.4.3 Evaluation of the diabetes prevention education sessions**

A total of thirteen bilingual health educators delivered education sessions. At the completion of the program, a comprehensive evaluation of the sessions was conducted with the BHEs. The evaluation focused on the impact of the training program on BHEs' self-rated abilities and the resources used during the education sessions.

A summary of the overall ratings is shown in the Table 6 and is followed by an analysis of the ratings.

**Table 6: Overall ratings of the diabetes prevention sessions**

	<b>Overall rating (out of 10)</b>
<b>Food-based activity as a teaching strategy</b>	9.2
<b>Usefulness of the BHE manual</b>	9
<b>Ability to answer women's questions</b>	9
<b>Confidence in delivering the sessions</b>	8.6
<b>Women's level of interest</b>	8.4
<b>Effectiveness of the case studies</b>	8.3
<b>Women's level of interaction</b>	8
<b>Covered the needs of the women</b>	7.8

*Food-based activities*

The highest and overall rating given to the food-based activity was **9.2** for effectiveness (on a scale of 1 to 10, with 1 being 'not at all' and 10 being 'extremely'). Eight of the thirteen (62%) BHEs who delivered sessions chose to use a food-based activity as a teaching strategy. In the words of two BHEs:

*'On the first session women provided refreshments which included cakes, sweets and deep fried food...at the end of the session I asked them to bring food next week based on the information received today and the changes they felt could be done. It was a success!! I also prepared fat-free food...'* (BHE)

*'...I used food models and I focused on the food I provided to talk about nutrition because they enjoyed eating the [healthy version of the] spring rolls and fried rice I provided and enjoyed how these foods were made and the proportion of the ingredients.'* (BHE)

In some cases, BHEs had to work within the women's community group usual practice and policies. One BHE rated the effectiveness of the activity a 10, but commented that community staff was required to handle the food for the elderly participants whereas it would have been more effective deliver the session on her own for the purposes of practical demonstration. In another session, one BHE reported that she instructed the community group's cook to prepare healthy food for the women during their education session.

### *The BHE Manual*

The usefulness of the BHE manual was given an overall rating of **9** (on a scale of 1 to 10, with 1 being 'not at all' and 10 being 'extremely').

### *Confidence and ability*

The bilingual health educators also rated their ability to answer women's questions an overall rating of **9** and self-rated their confidence in delivering the sessions only slightly lower at **8.6**. The confidence rating could be read in relation to the number of education sessions (five) delivered in English and the inherent challenges of using an interpreter. For all but one of the BHEs who delivered the sessions in English, it was the first time the BHE had delivered a session to the community group. In one instance, the Hindi-speaking BHE delivered a session to a Punjabi-speaking group, in both English and Hindi, so that the Punjabi-speaking interpreter could then interpret what was being said in Punjabi—a truly multilingual session!

### *Case studies*

It is interesting to note the overall rating given to the effectiveness of the case studies is **8.3** (on a scale of 1 to 10, with 1 being 'not at all' and 10 being 'extremely'). Only seven BHEs chose to use a case study during the sessions. A likely explanation for the slight drop in rating (a rating of **9** as was reported in the pilot project) was the BHE's choice to use other education strategies during the sessions, as several BHEs explained:

*'I did not use any of the case studies, using the women's personal stories and experiences was a lot more effective and kept them attentive, verbal, more engaged and happy to share experiences and knowledge.'* (BHE 8)

*'I had to allow the women to tell their own stories and introduce relevant information during the story-telling. I found it to be the only way.'* (BHE 9)

*'I asked the women if they knew about the different types of diabetes and one of them responded by telling her own story...another shared a story about her insulin-dependent mum who lives in Sudan.'* (BHE 10)

*'The case study I had inspired me to use some of the women's stories as there were a number of women who had type 2 diabetes and a few had gestational diabetes.'* (BHE 3)

Another BHE explained that the case studies were the least useful education resource for one particular group session because

*'...the women were more interested in direct information about diabetes not examples—they said that they have seen/heard of many instances where people talked about their own cases of diabetes.'* (BHE 12)

The example quoted above highlights the skills required of the BHE to assess and respond appropriately to the women's education needs.

#### *Level of interest and interaction*

The women's level of interest and women's level of interaction received an overall rating of **8.4** and **8** respectively (on a scale of 1 to 10, with 1 being 'poor' and 10 being 'excellent'). Although the ratings still represent a favourable rating, it also represents a slight drop in rating for women's level of interest and level of interaction compared with the sessions delivered during the pilot project, in which both factors rating 9.1. It is possible that the use of visual resources during the sessions could also impact on interest and interaction. One BHE rated the visual resources as the **most useful** education resources because she found 'the women look with interest and ask more questions.' (BHE 9).

#### *Covered education needs*

The extent to which the diabetes prevention education program covered the women's diabetes education needs received an overall rating of **7.8** (on a scale of 1 to 10, with 1 being 'not at all' and 10 being 'completely'). This aspect of the program received the lowest rating across the evaluation. However, in this instance, it is not possible to make a direct comparative assessment with the pilot program: this aspect of the program was not evaluated as such in the pilot project, instead BHEs were asked to evaluate across the five attributes of quality, comprehensiveness, clarity, appeal and the level of information provided.

The BHE Diabetes Project's focus was on training and providing resources for the BHEs, therefore emphasis was placed on evaluating the extent to which the program covered the *diabetes education needs* of the women. As such, an analysis of the (relatively) low rating assigned to meeting women's education needs can be made in relation to the other factors such as the type of resources available for use and the time allocated for the sessions. One BHE, for example, commented she would not change anything about the program except to recommend that the minimum delivery time for the sessions should be two hours.

Nevertheless, the lack of culturally-appropriate—specifically visual—resources continues to be an issue. One BHE commented that the **least useful** education resource was 'anything that was not visual', while several other BHEs commented in their evaluation:

*'As far as the group was concerned, resources in their language [Assyrian], directly relating to diabetes would have been greatly appreciated.'* (BHE 8)

*'Written material were least useful, women in general don't have much time to read, I told them to keep them as references but with family commitments as some are illiterate in their first language, that's why when they have visual resources it would benefit more.'* (BHE 9)

*'It's a pity other diabetes charts and posters were not available for the session day.'* (BHE 2)

The photographic guide to food serves, a resource recommended, endorsed and produced by dietitians, was considered to be one of **the most useful** education resources used during the program. Seven—over half—of the BHEs specifically nominated this resource and provided a comment as to its effectiveness in the education sessions:

*‘One elderly lady in the group wants to buy the book I used in the session. The majority of the audience were so impressed with this book and found it very interesting to know what a real serve size applies to a variety of fruit.’ (BHE 4)*

*‘I want to purchase it [the photo food guide] and keep it because the photos in this book shows clearly how big is a serve, but I did not use it in this session because I used food models and I focused on the food I provided...This group has booked another session about nutrition, I am going to use this book for that session.’ (BHE 3)*

The positive feedback received from all BHEs in relation to the photo guide’s effectiveness as an education resource demonstrates the need for additional visual resources which can be used and adapted across different language groups.

### **Box 3: The Karen-speaking sessions—a case study**

#### *Background*

The Karen are the largest ethnic minority group living in the mountain ranges of Burma and north western Thailand. Burma has over 135 ethnic groups with their own dialect, customs and beliefs (DIMA 2006). Karen-speaking people are spread over a large area, mainly on the Burma frontier with Thailand. The Karen, along with the Shan, Karenni and Mon minorities, have been the target of systematic human right violations by successive Burmese military regimes. A large proportion of minority groups have fled to Thailand despite the very poor conditions in the camps along the border. One camp, the Mae La camp started in 1984 as a small settlement for ethnic Karen fleeing violence in Burma. It has grown to be the largest of the nine refugee camps in the region. Over 2000-05, the two main ethnic groups of Burmese-born arrivals to Australia were Burmese (23%) and Karen (14%); however, during this period the ethnicity of approximately 60% of arrivals was not recorded (DIMA 2006). In 2008-09, Burmese refugees were the second largest group in Australia’s offshore humanitarian program (DIMA 2009: 79). About 60% of all-Burmese-born arrivals to Victoria since 1996 came under the humanitarian program.

While refugee experiences can vary considerably between individuals, most Burmese humanitarian entrants to Australia have been living in a camp environment prior to their arrival; many have been living in such conditions for more than a decade (DIMA 2006).

### *The education sessions*

Due to the unavailability of a Karen-speaking BHE, the MCWH's Thai-speaking BHE was assigned to conduct the sessions in English with the assistance of an interpreter. The decision to use a Thai-speaking BHE for the sessions was based on geography as much as availability, with Thailand being the country to which the majority of Burmese refugees have fled. Despite initial concerns about the cultural and political appropriateness of having a Thai woman present the sessions, issues relating to ethnicity and/or nationality were not raised by any of the Karen women during the sessions.

Almost all the Karen-speaking women in the education sessions, most of whom were newly-arrived from refugee camps, did not speak or read English. The sessions were delivered over two weeks in two 2-hour sessions. For the Karen education sessions, the BHE relied on visually oriented strategies—including writing simple words on the whiteboard and using the photo guide to food serves—to convey the key messages to the group. The BHE also focused on encouraging women to contribute to the sessions by asking them questions. This process was effective in breaking up the two-way flow of communication between the BHE and the interpreter and allowed the woman to interact during the session. For example, women took in turns to answer 'What do you usually eat for breakfast?' The general answer being 'Every day we eat rice, three times a day'; and when asked, 'Do the men in your community cook regularly?' The general answer was 'Yes, cooking and shopping for the family is important.'

When asked by the BHE if anyone in the group had heard of diabetes, one woman told the others she had been diagnosed with type 2 diabetes during her time in the refugee camp. However, the woman appeared disinclined—whether due to language difficulties or otherwise—to talk further about her condition. The BHE immediately acknowledged the woman's reluctance and focused her attention on conveying key messages about diabetes in other ways.

For the second session, the BHE opted to use food label-reading as an activity in addition to providing healthy food/products, which were given to the women to take home after the session. Although there were initial concerns about the appropriateness of the label-reading activity because of the low English literacy level with the group, the activity proved to be effective, especially in capturing women's interest and attention. Women with lower English proficiency were paired up with another woman in the group who could assist them through the exercise. Key messages were confined to healthy levels of 'fat' and 'sugar' with the daily requirements written numerically on the whiteboard. In this regard, low English proficiency was used as an opportunity to also teach the women a few basic words in English (see Images 1, 3 and 4).

Currently, there are no diabetes prevention education resources that are readily available in the Karen language. While some U.S.-based education materials can be found on-line, topics do not relate to diabetes prevention and refer only to the American health care system.

The complexities and challenges of delivering health education to immigrant and refugee women in languages other than English extend beyond language. Culturally-appropriate education extends to issues of gender, age, ethnicity, culture, sexuality and religion. The challenges encountered by Rachanee, the BHE who delivered the education sessions for the Karen-speaking women (see case study) summarise and highlight the importance of the bilingual health educator who has been appropriately-trained to customise, deliver and facilitate sessions. When asked about improvements to the diabetes education program, Rachanee offered the following recommendations:

‘Visual resources which are less reliant on English...the educator is in a better position to know how and what to add or reduce the information in order to suit the group. The program has to have extensive resources in all forms so the educator has more selections.’ (Rachanee, BHE)

The availability of education resources (visual and otherwise) and professionally-trained bilingual health educator are not mutually exclusive factors in diabetes prevention education. The development of education resources for immigrants and refugees needs to be considered not only with regard to English proficiency, but also to the ways in which visual messages are ‘read’ and understood by individuals and within different cultural contexts. Equally, BHEs need to be adequately and appropriately resourced, including on-going training, in order to meet the health education needs of immigrant and refugee women and their families.

## **4. CONCLUSION: KEY RECOMMENDATIONS**

The diabetes prevention education BHE resource development workshop, the diabetes training program for BHEs and the community education sessions carried out as part of the BHE Diabetes Project proved to be a success. The thirty education sessions conducted over two months with 258 women in community settings exceeded the project target. Demand for the sessions continues and points to an ongoing need for diabetes prevention education for immigrant and refugee communities.

Other issues and gaps identified in program delivery which require attention:

### **4.1 Diabetes prevention education**

- Education should be delivered by a bilingual health educator who has been trained across a range of health-related areas.
- High-quality, culturally-appropriate, multilingual resources need to be developed in a wide range of formats (i.e. posters, models, information sheets, equipment for group exercises and demonstrations). Resources should be developed and/or updated for new and emerging communities, as well as well-established communities.
- The MCWH diabetes prevention education BHE manual should be produced and made available to health and welfare service providers.
- The diabetes prevention education program should be extended for delivery to immigrant and refugee women in the workplace, in addition to community settings.

### **4.2 Training/continuing education**

- Bilingual health educators require on-going training and professional development to update and refresh their skills and knowledge.
- Bilingual health educators need to be fully supported in their role, including being provided with clear program and education delivery guidelines. Factors such as regular and ongoing supervision, the provision of reliable transport, and the provision of extensive equipment/education resources are crucial to BHEs' effectiveness.

### **4.3 Adequate resourcing**

- Bilingual health educators play a significant role in the health and wellbeing of immigrant and refugee communities and need to be considered as an integral part of health service sector delivery. Successful and sustained diabetes prevention education programs require significant government support and should be adequately funded.

#### 4.4 Research

- Rigorous, long-term academic research (including impact and process evaluations) needs to be conducted to ensure findings from the MCWH diabetes prevention education program can be added to the evidence base. More specifically:
  - Further research needs to be conducted with immigrant and refugee women in order to evaluate the health outcomes of the diabetes prevention education program.
  - A gendered approach is crucial when considering research with immigrant and refugee women. Narrative-based enquiries, which acknowledge and respect knowledge women have about their bodies, align with the principles and values of a gendered approach, as well as that of community-based care.
  - There are currently no universally accepted standards, qualifications or assessment measures for BHEs, further research on the BHE workforce can improve conceptualisations and definitions of the BHE role and improve research in the area.

# APPENDICES



## **Appendix A: Project Participants**

### **Project Staff:**

Maud Moses  
Regina Quiazon

### **Training Program Presenters:**

Deborah Boyce, Mercy Hospital for Women  
Julie Lew, Merri Community Health  
Roger Lindenmayer, North Richmond Community Health Centre  
Catherine McNamara, Mercy Hospital for Women

### **Bilingual Health Educators:**

Sonali Deshpande  
Rebecca He Li  
Wafa Ibrahim  
Marianna Jerbic  
Victoria Lolika  
Mahdokht Mahboobi  
Violetta Marciano  
Rachanee Naksuk  
Hien Tran  
Irina Zdravevska

### **Host organisations for the education sessions:**

Boroondara Chinese Senior Citizen's Association  
Loddon Campaspe Multicultural Services  
Spectrum Migrant Resource Centre  
Wellsprings for Women  
Wesley Footscray Outreach  
Whittlesea Community Connections



## Appendix B: BHE Resource Development Workshop Program

### Bilingual Health Educators Project: Workshop Program Outline 11th November 2009

**Facilitators:** Maud Moses and Regina Quiazon (MCWH Project Officers)

Time	Topic
9.30 – 9.45	<b>Introduction and overview</b>
9.45 – 11.00	<p><b>Session 1: Reflecting on the MCWH approach to diabetes education prevention</b></p> <p>Aim: To provide a context for thinking about improvements to the diabetes health education program.</p> <p>Objectives: BHEs will be asked to reflect on their role in relation to the principles and practices underlying the MCWH model of health education in order to:</p> <ul style="list-style-type: none"> <li>▪ Reinforce understandings of adult learning theory and principles</li> <li>▪ Increase awareness of and knowledge about participatory peer education</li> <li>▪ Develop an understanding of notions of good practice in health education</li> </ul>
11.00 – 11.15	<i>Short break</i>
11.15 – 12.30	<p><b>Session 2: The Case Studies: Results, Options and Evaluation</b></p> <p>Aim: To apply information gained from storytelling to the development of health promotion materials (i.e. case studies).</p> <p>Objectives: By the end of this session, BHEs should be able to:</p> <ul style="list-style-type: none"> <li>▪ identify their own professional learning needs based on women's stories of illness and health care encounters</li> <li>▪ give a basic account about how diabetes affects women's health and life choices</li> </ul>
12.30 – 1.00	<i>Lunch</i>
1.00 – 2.15	<p><b>Session 3: The Resources: Results, Options and Evaluation</b></p> <p>Aim: To apply information gained from evaluative thinking to the development of diabetes prevention resources.</p> <p>Objectives: By the end of this session, BHEs should be able to:</p> <ul style="list-style-type: none"> <li>▪ develop an understanding of evaluative reasons or logic</li> <li>▪ select information and resources to meet particular needs</li> </ul>

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<b>2.15 - 2.30</b>	<i>Short break</i>
<b>2.30 – 3.30</b>	<b>Session 4: The Education Program: Results, Options and Evaluation</b>  Aim: To explore the scope of the <i>Diabetes Healthy Living Education Program</i> .  Objectives: By the end of this session, BHEs should be able to: <ul style="list-style-type: none"><li>▪ identify and address their own professional teaching and learning needs based on their reflections</li><li>▪ evaluate each session of the program in terms of both content and process</li></ul>
<b>3.30 – 3.45</b>	<b>Workshop Evaluation</b>

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## Session 1

### Reflecting on the MCWH Approach to Diabetes Education Prevention

#### **Aim**

To provide a context for thinking about improvements to the diabetes prevention health education program.

#### **Objectives**

BHEs will be asked to reflect on their role in relation to the principles and practices underlying the MCWH model of health education in order to:

- Reinforce understandings of adult learning theory and principles
- Increase awareness of and knowledge about participatory peer education
- Develop an understanding of notions of good practice in health education delivery

#### ➤ **Exercise 1 (a)** **Health promotion and education: who is it for?**

##### ***Reflective Practice***

- i) **Brainstorm** as many images, descriptive words or adjectives (in English or in your native language) for 'health' or 'healthy' as you can in five minutes. Use direct or slang words if that helps. These are descriptions of *your* health, e.g. sunshine, strong, glowing, fresh food, alive, vigor....
- ii) **Now make a list** of activities, events, practices or states in your own personal life, which make you feel like the words you have used. Find a way of listing that might be surprising – we'll pool our answers to ensure they remain anonymous e.g. dancing in the lounge, sleeping in during winter, leaving a difficult workplace...
- iii) **Finally, make an imaginative list** of people, organisations and/or activities that would help you achieve your list of activities – there are no limits to what this person/people or organisation/s can do, only that they can help you achieve whatever makes you feel healthy e.g. door knock to organise Tai Chi in the local park at 7a.m.; small dance group of parents with children; establish a neighbourhood babysitting circle.

#### ➤ **Exercise 1 (b)** ***Basic Principles of Adult Learning – Group Activity***

BHEs will contribute to the development of a Bilingual Health Educator Adult Learning Toolkit, which will assist BHEs to facilitate learning during the education sessions with women.

(Handout: 'MCWH Bilingual Health Educators' Toolkit: Basic Principles of Adult Learning')

- Short break -

## Session 2

### The Case Studies: Results, Options and Evaluation

#### Aim

To apply information gained from storytelling to the development of health promotion materials (i.e. case studies).

#### Objectives

By the end of this session, BHEs should be able to:

- identify their own professional learning needs based on women's stories of illness and health care encounters
- give a basic account about how diabetes affects women's health and life choices

#### ➤ Exercise 2

Tell a story about a person with diabetes in the first person, that is, *as if it were you*. It should be based on the experiences of a real person—a relative, a friend, a woman who was in your education session, or even yourself! Start the story: "My name is...and I have diabetes. This is about how the illness affects my life and about my hopes and fears".

THEN

After each person has shared their story, identify three things that you might need to learn to help the person's situation.

-Lunch-



## Session 3

### The Resources: Results, Options and Evaluation

#### Aim

To apply information gained from evaluative thinking to the development of diabetes prevention resources.

#### Objectives

By the end of this session, BHEs should be able to:

- develop an understanding of evaluative reasons or logic
- select information and resources to meet particular needs

#### ➤ Exercise 3

**Thinking about evaluation: Comparing Mugs**

- Short break -



## Session 4

### The Education Program: Results, Options and Evaluation

#### Aim

To explore the scope of the *Diabetes Healthy Living Education Program*.

#### Objectives

By the end of this session, BHEs should be able to:

- identify and address their own professional teaching and learning needs based on their reflections
- evaluate each session of the program in terms of both content and process

(Handout: 'Structure of the *Diabetes Healthy Living Education Sessions 2008*')



# Appendix C: BHE Resource Development Workshop Evaluation Survey

## BHE PROJECT WORKSHOP EVALUATION 11th November 2009 at MCWH

Please circle your responses to the items. Rate aspects of the workshop on a 1 to 5 scale:

- 1 = 'strongly disagree', most negative impression
- 2 = 'disagree'
- 3 = 'neither agree or disagree'
- 4 = 'agree'
- 5 = 'strongly agree', or the most positive impression

### 1. Overall

	<i>SD</i>			<i>SA</i>	
	1	2	3	4	5
I was well informed about the aim of this workshop					

### 2. The Workshop Content

The workshop objectives were clear to me	1	2	3	4	5
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The workshop activities stimulated my learning	1	2	3	4	5
--	---	---	---	---	---

The length of the workshop was appropriate	1	2	3	4	5
--	---	---	---	---	---

The pace of the workshop was appropriate	1	2	3	4	5
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The content was relevant to my work as a BHE.	1	2	3	4	5
---	---	---	---	---	---

The workshop covered relevant issues	1	2	3	4	5
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What information was *most* relevant and/or valuable to your work as a MCWH BHE?

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What information was *least* relevant and/or valuable to your work as a MCWH BHE?

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### 3. Workshop Results:

The workshop was a good way for me to think more critically and deeply about my work as a BHE	1	2	3	4	5
---	---	---	---	---	---

I will be able to use what I learned in this workshop	1	2	3	4	5
---	---	---	---	---	---

I was able to contribute to discussions	1	2	3	4	5
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### 4. Workshop Facilitators

The facilitators were well-prepared	1	2	3	4	5
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The facilitators were informative	1	2	3	4	5
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## 5. The Workshop has...

...reinforced my understanding of adult learning theory and principles

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<i>Not at all</i>				<i>Somewhat</i>					<i>Completely</i>

...increased my knowledge about participatory peer education

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<i>Not at all</i>				<i>Somewhat</i>					<i>Completely</i>

...given me an understanding of good practice in health education delivery

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<i>Not at all</i>				<i>Somewhat</i>					<i>Completely</i>

...helped me to identify my learning needs as a BHE

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<i>Not at all</i>				<i>Somewhat</i>					<i>Completely</i>

...increased my understanding of storytelling techniques

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<i>Not at all</i>				<i>Somewhat</i>					<i>Completely</i>

...increased my understanding of evaluative thinking

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<i>Not at all</i>				<i>Somewhat</i>					<i>Completely</i>

## 6. Improvements

How could the workshop have been improved? (Check all that apply)

- Provide better information before the workshop
- Clarify the workshop objectives
- Reduce the content covered
- Increase the content
- Improve the instructional methods
- Make the workshop activities more stimulating
- Improve workshop organisation
- Slow down the pace
- Speed up the pace
- Allot more time for the workshop
- Shorten the time for the workshop

What other improvements would you recommend?

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Any other comments or suggestions?

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## Appendix D: BHE Diabetes Prevention Education Training Program

### Day 1: Wednesday, 10<sup>th</sup> March

Time	Topics	Facilitator / Presenter
9.30-9.45	Introduction and Overview	Maud Moses and Regina Quiazon, MCWH Project Officers
9.45-10.30	Revision: Diabetes 101	Maud Moses and Regina Quiazon
10.30-11.30	Diet and nutrition: The meaning of healthy eating.	Julie Lew, Dietitian, Merri Community Health Service
11.30-11.45	<i>Short Break</i>	
11.45-13.00	Diet and nutrition: All about fats	Julie Lew, Dietitian, Merri Community Health Service
13.00-13.30	<i>Lunch</i>	
13.30-15.00	What is diabetes?	Roger Lindenmayer Diabetes Educator North Richmond Community Health Centre
	<i>Short Break</i>	
15.15-16.00	Gestational Diabetes	Deborah Boyce and Cath McNamara Diabetes Educators Diabetes in Pregnancy Unit, Mercy Hospital for Women

### Day 2: Friday, 12<sup>th</sup> March

Time	Topics	Facilitator/Presenter
9.30-10.00	'My experience with diabetes...' A Round Table Discussion	[Woman from a migrant community who is managing diabetes]
10.00-11.30	Diet and nutrition: Carbohydrates and sugar	Julie Lew
11.30-11.45	<i>Short Break</i>	
11.45-13.00	Diet and nutrition: Label Reading	Julie Lew
	<i>Lunch</i>	
13.30-15.00	Diabetes Prevention: Complications and Management	Roger Lindenmayer
	<i>Short Break</i>	
15.15-16.00	Resources & Program Overview	Regina Quiazon

















19. Did women request any education material? Yes  No

In English  in their language

Please provide details of the women's request(s)

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20. Can you comment on the effect the program had on women's knowledge, attitudes and practices around diabetes.

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21. The **most valuable** messages for the women were...

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### Improvements and Additional Comments

22. Overall, how can the diabetes education program be improved (omissions, changes, additional or fewer information, teaching strategies, resources etc) so it is relevant and culturally-appropriate for women in your community?

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Any other comments?

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## Appendix G: BHE evaluation of most useful and least useful resources

Language group	The most useful education resource	The least useful education resources
<b>Arabic</b>	<ul style="list-style-type: none"> <li>The photo guide to food serves</li> <li>'Understanding Diabetes' poster</li> </ul>	<ul style="list-style-type: none"> <li>Written materials</li> </ul>
<b>Assyrian</b>	<ul style="list-style-type: none"> <li>Food activity including portion plate</li> </ul>	(None)
<b>Cantonese</b>	<ul style="list-style-type: none"> <li>The BHE manual</li> <li>The BHE resource folder</li> </ul>	('All relevant and useful')
<b>Croatian</b>	<ul style="list-style-type: none"> <li>Laminated booklet</li> <li>Internal organs of the human body</li> </ul>	<ul style="list-style-type: none"> <li>Case studies</li> </ul> <p>('...in this instance women were interested in direct information about diabetes not examples...')</p>
<b>Dari</b>	<ul style="list-style-type: none"> <li>The BHE manual</li> </ul>	('They are all good')
<b>Italian</b>	<ul style="list-style-type: none"> <li>The posters</li> <li>Photo guide to food serves</li> </ul>	'Anything that was not visual'
<b>Karen</b>	<ul style="list-style-type: none"> <li>Body diagram</li> <li>Photo guide to food serves</li> </ul>	<ul style="list-style-type: none"> <li>Written resources in English</li> </ul>
<b>Macedonian</b>	<ul style="list-style-type: none"> <li>The case study</li> </ul>	('They were all very useful...')
<b>Polish</b>	<ul style="list-style-type: none"> <li>Anatomical poster</li> <li>The photo guide to food serves</li> </ul>	('They are all good—depends what type of group they are used for, older/younger generation.')
<b>Punjabi</b>	<ul style="list-style-type: none"> <li>Handouts and charts from MCWH</li> </ul>	(None)
<b>Somali</b>	<ul style="list-style-type: none"> <li>The photo guide to food serves</li> <li>Food models</li> </ul>	<ul style="list-style-type: none"> <li>Food package labels (women did not know how to read)</li> </ul>
<b>Sudanese Arabic</b>	<ul style="list-style-type: none"> <li>All</li> </ul>	(None)
<b>Vietnamese</b>	<ul style="list-style-type: none"> <li>Food packages</li> <li>'Understanding Diabetes' poster</li> <li>Food models</li> <li>Portion size plate</li> <li>Food pyramid poster</li> <li>Translated material</li> <li>The photo guide to food serves</li> </ul>	<ul style="list-style-type: none"> <li>Gestational diabetes DVD</li> <li>Diabetes Australia 'Diabetes' Large Format Laminated booklet</li> </ul>



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